Operating standards for care homes
May 2017

Contents
1. Oral hydration ................................................................. 3
2. Nutrition ............................................................................... 9
3. Tissue viability ........................................................................ 13
4. Continence care ....................................................................... 15
5. Infection prevention ................................................................ 18
6. Dementia care ......................................................................... 22
7. Parkinson’s and the management of acute deterioration of symptoms ........................................... 25
8. Use of medical devices .............................................................. 28
9. Long term conditions and frailty case management .......................................................... 30
10. Care planning and record keeping .................................................. 32
11. Dignity and respect ................................................................. 33
12. Clinical supervision .................................................................. 35
13. Safeguarding adults .................................................................. 37
14. Incident reporting ...................................................................... 38
15. Incident reporting ...................................................................... 40
16. Human resources ...................................................................... 42
17. Managing complaints ................................................................. 44
18. Whistleblowing ........................................................................ 45
19. Medicines management ............................................................... 47
20. Clinical skills and procedures ....................................................... 50
21. End of life care ......................................................................... 52
22. Diabetes .................................................................................. 55
23. Risk of VTE in care homes ......................................................... 58
24. One to one in the care home setting ............................................. 60
1. Oral hydration

**Top overview**
Oral hydration refers to the basic act of ‘drinking’. Water is essential for:

- Transporting and utilising oxygen, nutrients, vitamins, enzymes and medications;
- Controlling the internal body temperature and blood chemistry;
- Maintaining an adequate blood pressure; and
- Removing waste products and toxins.

It is our primary and most important nutrient which explains why a person can only survive a few days without water, in contrast to several weeks without food. In daily life if a person does not regularly drink enough to replace daily fluid loss, they will be at risk of dehydration and more prone to illness and injury.

Throughout life it is our ‘sense of thirst’ that ultimately reminds us to regularly drink more water to keep the body adequately hydrated. However, in older age the sense of thirst is less effective at reminding a person to drink more. This explains why all elderly people should automatically be considered to have an increased risk of dehydration compared to younger generations. It also explains why many elderly people comment that they don’t feel as thirsty as they used to, and are less inclined to finish daily routine drinks, or simply do not think about the need to have extra sips of water throughout the day.

Furthermore, many people living in residential and nursing homes have a much greater risk of dehydration because they are reliant on a carer to give them some level of assistance or encouragement to drink, and / or suffer with a swallow problem. The presence of advancing dementia is also known to increase a person’s risk of dehydration. Increasing evidence suggests that 40-50 per cent of elderly patients admitted to hospital will be dehydrated and care home residents are ten times more likely to be dehydrated than those admitted from a domestic home (Wolff et al 2015).

The human suffering caused by dehydration remains a national concern; and is increasingly seen as an indicator of neglect within the care environment (SCIE 2009; NICE 2010; CQC 2010; CQC 2013; NHS England (2015); NICE 2015; NMC 2015; Think Kidneys 2016; KSS AHSN 2017).

The most common type of dehydration in the elderly population is ‘chronic’, meaning that it develops slowly over several days, weeks or months. Quite simply it is caused by a person not regularly drinking enough to replace essential daily fluid loss, and results in a ‘sub-optimal hydration level’. Because it develops slowly it often goes
unnoticed, however, it is considered the underlying cause of urine infections, constipation, dizziness and falls, lethargy and mild confusion as well as exacerbation of long term conditions and risk of pressure ulcers, malnutrition, poor oral health, deep vein thrombosis and medication toxicity.

There is no simple test to diagnose ‘sub-optimal hydration’, added to which many of the signs and symptoms e.g. dry inelastic skin, increased sleepiness, poor concentration, lethargy and confusion are also associated with the natural aging process, dementia, and mental health issues, thus making it difficult for medical and nursing staff, carers and family members to differentiate. These combined factors highlight the importance of routinely monitoring daily drinks and urine output as part of essential daily care.

If chronic dehydration is not recognised and simple measures are not taken, such as regularly prompting a person to drink more, it can result in severe symptoms linked to delirium, including unexplained agitation or sleepiness or acute kidney injury (AKI) whereby there is a sudden reduction or cessation of urine output caused by low blood pressure due to dehydration; AKI is a life threatening condition, diagnosed by blood tests.

In contrast ‘acute onset’ dehydration affects all ages and develops very rapidly, accompanied by loss of salts as well as water, due to sudden unexpected fluid loss caused by diarrhoea and vomiting or profuse sweating caused by fever, high environmental temperature or physical exertion. Sweating helps maintain the internal body temperature within a safe range, if a person does not drink enough to replace the water loss, the body will become dangerously over heated causing sudden collapse or death. It stands to reason that if a person is already suffering with chronic dehydration it will make them more vulnerable to the effects of acute onset dehydration. Both chronic and acute onset dehydration can result in a medical emergency. Clinical signs and symptoms such as low blood pressure, weak pulse, raised respirations, cold extremities, delayed capillary refill, altered conscious level, significantly reduced urine output all require urgent medical review and intervention.

In general terms, an average person should aim to drink at least 1,500mls to help keep the body adequately hydrated. This is the equivalent of approximately six to eight drinks per day. The body needs this amount of water to support healthy kidney function so that waste products can be excreted in essential urine production. When a person does not drink enough, the kidneys will try to conserve water, resulting in more concentrated urine, which is darker and stronger smelling. However, it is important to note that in older age the kidneys become less effective at conserving water and recent evidence confirms that urine volume and colour is not a reliable indicator for diagnosing dehydration as a standalone clinical sign (Hooper and Bunn 2015). Although, in practical terms, if there is a noticeable change to normal urine colour or output dehydration should always be excluded first. Failure to do this could result in preventable harm.

It is widely recognised that many frail or vulnerable people are unable or unwilling to routinely drink 1,500mls and as such have an increased risk of dehydration and
require nurses and carers to continuously make all reasonable efforts to assist and encourage them to drink as best they can, to achieve their personal optimal fluid intake. Identifying who is at risk and providing the correct level of support is paramount to preventing avoidable ‘unnecessary’ dehydration (Campbell 2016). Evidence confirms that residents who miss drinks in-between meals are more likely to be dehydrated (Hooper and Bunn 2015).

Food also supports hydration and a well-balanced diet provides on average an additional 800mls per day, however this is counter balanced by daily water loss that cannot be seen (known as insensible water loss) through breathing and the skin. Therefore, if a person routinely eats less than half of their meals, this further increases risk of dehydration.

Drinking (oral hydration) is one of life’s simple pleasures as well as an integral part of daily routine and social interaction. However, many elderly people choose to limit fluid intake because they are worried about incontinence or fear of falling when walking to the toilet. Whilst this is understandable, sadly this habit increases risk of urine frequency and falls. Adopting a wide range of strategies to raise awareness about the importance of hydration, social interaction and providing timely continence support will help reduce the risk of dehydration (Water UK 2006; British Dietetic Association 2012; KSS AHSN 2017).

Key points: elderly people are at greater risk of dehydration due to:

- A ‘reduced thirst response’ which diminishes the natural trigger to drink;
- Reduced kidney function;
- Reliance on carers to assist and encourage with drinking due to physical, neurological or cognitive impairments;
- Poor food intake;
- Fear of incontinence; causing people to limit how much they choose to drink;
- Problems with swallowing;
- Diuretic and laxative medications; and
- Inadequate staffing levels (Mentes, 2006).

**Commissioner requirements**

The commissioner requires that all providers will ensure that they deliver high quality oral hydration care to all residents and follow current local and national guidance to prevent ‘avoidable’ dehydration caused by lack of basic care.

**Providers will:**

- Provide safe oral hydration care with dignity and respect offering a choice of drinks that takes account of people’s individual preferences, special requirements and diverse needs.
- Assess the person’s ability to safely swallow fluids and refer to a speech and language therapist as appropriate.
• Ensure all persons with an identified swallowing problem (dysphagia) receive the correct consistency of thickened fluids (National Dysphagia Diet Food Texture Descriptors 2012).

• Screen all residents on arrival and thereafter on a regular basis to determine the level and type of assistance and encouragement needed to support a person to drink; using the ROC to Drink (Reliance On a Carer) dehydration risk assessment tool and care plan summary, and ROC Supporting Guidelines for communication, manual handling, mouth care and continence.

• Ensure all individuals have access (or are offered) drinks 24/7 to meet individual needs. If unsafe to leave the drink in reach and / or has a fluid restriction, enter specific details in the care plan.

• Provide person centred care by including the individual person and or their family or carer when assessing, planning and monitoring drinks services and oral hydration care.

• Continuously monitor how much individuals are drinking and take action as necessary to support adequate fluid intake: Staff should be aware of the volume for all drinks containers.
  - Document all above findings in the individual’s personal care plan and create an action plan to ensure all hydration care requirements are met and monitored and the action plan is regularly reviewed and updated according to need;
  - Provide clear verbal and written communication to all staff that is responsible for purchasing, preparing, serving or assisting with drinks to ensure they understand what to do to meet the agreed action plan;
  - Ensure staff working at all levels of the organisation have the appropriate skills and competencies and receive regular training to provide safe hydration care within their individual scope of practice, and can recognise signs and symptoms associated with mild, moderate and acute dehydration caused by chronic or acute onset dehydration;
  - Ensure all staff or volunteers responsible for assisting a person to eat or drink has had appropriate training to:
    o Safely assist and encourage a person to drink or eat;
    o Monitor food and fluid intake; and
    o Communicate or escalate any concerns.
  - Ensure high quality timely continence care to support oral hydration care.
  - Monitor urine output and seek urgent medical review if the individual has a greatly reduced or no urine output over a six hour period, during waking hours;
  - Seek medical review if despite best efforts adequate oral hydration cannot be achieved to prevent worsening signs of dehydration e.g. reduced urine output, raised pulse and respiratory rate, postural hypotension, increased sleepiness or confusion;
  - Promote the importance of capturing real time feedback from residents, visitors and staff to prompt immediate response to poor oral hydration care and take action as necessary;
  - Ensure drinking equipment is available to support independence and personal choice;
  - Provide residents with information about the benefits of hydration; and
Nominate a link/resource nurse for the promotion of oral hydration.

Quality indicators
- All residents are regularly screened using the:
  - ‘ROC to Drink’ – (Reliance on a Carer to Drink) Dehydration Risk Assessment Tool and Care Plan Summary Guideline, to assess the level and type of support needed to achieve optimum oral hydration. Access ‘ROC’ at [www.simplemeasures.co.uk/membership-signup/](http://www.simplemeasures.co.uk/membership-signup/)

Supporting information
- Care Quality Commission (CQC) Regulation 14: Meeting nutritional and hydration needs: [http://www.cqc.org.uk/content/regulation-14-meeting-nutritional-and-hydration-needs](http://www.cqc.org.uk/content/regulation-14-meeting-nutritional-and-hydration-needs)
• ROC to Drink (Reliance On a Carer): https://www.simplemeasures.co.uk/
2. Nutrition

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<tr>
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<tr>
<td>Nutrition</td>
<td>Naomi Campbell</td>
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**Topic overview**

The operating standards for nutrition and hydration (eating and drinking) are addressed separately. However, it is recognised that nutrition and hydration are interwoven in daily care and as such there will be general reference to hydration within this operating standard.

Appropriate and adequate nutritional care is vital to the overall health of all patients and service users. Malnutrition occurs when a person does not regularly have enough to eat or has inadequate nutrients due to a prolonged poor diet or problems absorbing nutrients; resulting in poor outcomes of care and increased risk of mortality due to:

- Vulnerability to infection;
- Delayed wound healing;
- Impaired function of heart and lungs;
- Decreased muscle strength;
- Depression; and
- Increased risk of dehydration (a balanced diet provides 20 per cent of daily fluid intake).

Studies in the UK show that malnutrition is surprisingly common in the UK with 1:3 people admitted from the community into care homes and hospitals already suffering with malnutrition (BAPEN 2012). The elderly are at greatest risk due to reduced mobility, long term health problems, dementia, socio-economic pressures, depression or a dependency on others to prepare food or to assist with eating and drinking.

Malnutrition continues to be under-recognised and under-treated and is both a cause and a consequence of ill-health and can be life threatening. The validated 5 step ‘Malnutrition Universal Screening Tool’ (MUST) provides a standardised approach for all providers in health and social care to identify those people at risk of malnutrition and prompts an action plan (NICE 2006; BAPEN 2011). However, MUST does not screen for risk of dehydration.

To reduce the incidence of malnutrition it requires consistent and integrated strategies to detect, prevent and treat malnutrition within and between all care settings. (NICE 2006; CQC 2010; BAPEN 2011, British Dietetic Association (2012).
Commissioner requirements
The commissioner expects that all providers will ensure that they deliver high quality nutrition and hydration to all patients with dignity and respect, to meet individual needs in accordance with national standards; delivering best practice at all times.

Providers will:
- Provide a 24/7 food and drinks service that delivers a nutritionally balanced diet to meet the individual needs of the people in their care.
- Screen all people on admission to identify risk of malnutrition using the validated five step ‘Malnutrition Universal Screening Tool’ (MUST) and thereafter on a routine monthly basis or more frequently if there is a clinical need.
- Assess, plan and set goals to maintain, increase nutritional intake in response to step five of MUST; management guidelines.
- Ensure appropriate use of Oral Nutritional Supplements (ONS) and provide support as needed to drink or eat ONS.
- Refer to the British Dietetic Association (2012) for guidance on fortification of food and beverages and seek the advice of a doctor or specialist nurse if there are concerns about specific dietary needs.
- Ensure all persons with an identified swallowing problem (dysphagia) receive the correct consistency of food or thickened fluids (National Dysphagia Diet Food Texture Descriptors 2012).
- Assess all people on admission to identify the level of assistance and encouragement a person needs to eat; using the assessment tool ‘Reliance On a Carer’ (ROC) to Eat.
- Continuously assess the correct level of support is always provided and monitor intake of meals and snacks.
- Provide person centred care by including the individual person and or their family or carer when assessing, planning and monitoring food and drinks services.
- Assess the person’s ability to chew and dental requirements e.g. dentures
- Provide support with routine mouth care if needed.
- Provide safe nutritional care with dignity and respect offering a choice of food and drink that takes account of people’s individual preferences, special dietary requirements, and diverse needs.
- Provide sufficient amounts of food and appropriate portion sizes to prevent or reduce the risk of unplanned or unexpected weight loss. Offer choice of finger foods as appropriate.
- Provide alternative choice if a person does not like the food offered.
- Serve food and drinks at the correct temperature.
- Provide adaptive equipment to support optimum independence.
- Ensure they allow individuals to choose when and where and with whom they want to eat and drink, providing at all times a service and environment conducive to people enjoying their meals; always having available a communal dining room to encourage social interaction.
- Ensure all individuals who are unable to consume food orally or cannot achieve an adequate intake have alternative provision in accordance with NICE guidelines (Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition 2006).
Operating standards for care homes
May 2017

- Document all above findings in the individual’s personal care plan and create an action plan to ensure all nutrition and hydration care requirements are met and monitored and the action plan is regularly reviewed and updated according to need.
- Provide clear verbal and written communication to all staff who are responsible for purchasing, preparing, cooking, serving or assisting with food and drinks to ensure they understand what to do to meet the agreed action plan.
- Ensure staff working at all levels of the organisation have the appropriate skills and competencies and receive regular training to provide safe nutritional care within their individual scope of practice.
- Ensure all staff or volunteers responsible for assisting a person to eat or drink has had appropriate training to:
  - Safely assist and encourage a person to eat or drink;
  - Monitor food and fluid intake; and
  - Communicate or escalate any concerns.
- Ensure all staff responsible for carrying out nutritional screening have received adequate training and have the appropriate resources; this includes access to weighing scales that are regularly calibrated.
- Nominate a link/resource nurse for the promotion of nutrition and hydration.

Quality indicators
- All residents are regularly screened using the MUST tool (Malnutrition Universal Screening Tool) to identify risk of malnutrition.
- All residents are regularly screened to identify the level and type of support needed to eat using the ‘Reliance on a carer (ROC) to eat’ and Care Plan Summary Guideline: www.simplemeasures.co.uk/membership-signup/

Supporting information
- BAPEN (2012): Nutritional Screening Survey in the UK and Republic of Ireland 2010
- Care Quality Commission (CQC) Regulation 14: Meeting nutritional and hydration needs: http://www.cqc.org.uk/content/regulation-14-meeting-nutritional-and-hydration-needs
Operating standards for care homes
May 2017

- ROC to Eat (Reliance On a Carer): https://www.simplemeasures.co.uk/
3. Tissue viability

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<tr>
<td>Tissue viability</td>
<td>Nicci Aylward-Wotton</td>
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**Topic overview**

Care homes provide care for an increasing number of elderly residents at varying stages of dependence. The level of which appears to be increasing (Blood 2010). In view of this, the risks to residents of developing pressure ulcers increases. Equally the scale of knowledge required by carers in care homes must increase in order to provide a high standard of physical care and therefore prevent pressure ulcers. It is important that care home residents do not become compromised with regards to wound care needs.

Pressure ulcers affect 20 per cent of people in acute care, 30 per cent of people in the community and 20 per cent of people in nursing and residential homes (Clark et al, 2004). The consequences of pressure ulcers should not be underestimated. Not least in terms of financial cost to the NHS (2.3–3.1 billion a year (Posnett and Franks, 2007)) but more importantly to the physical and psychological impact on the individuals that are involved. The potential to die from a severe pressure ulcer is also a very real prospect. In 2010, 218 people died in hospitals and care homes in England and Wales where the cause of death was recorded as bedsores (Donnelly and Clayton 2012). In addition, 25,343 died of other causes while suffering from a pressure ulcer (Donnelly and Clayton 2012). Considering that in most cases pressure ulcers are preventable most of these deaths are avoidable occurrences (Institute for Healthcare Improvement, 2011). In some cases health professionals and/or organisations are being held accountable if a person develops a pressure ulcer while in their care (Guy, 2010). This is in recognition of a failure to provide sufficient care resulting in neglect and abuse (Clarkson 2007). With respect to the 25,343 who died with the addition of a pressure ulcer this raises the question of prevention strategies and standards of care of patients in the latter stage of their lives have received.

**Commissioner requirements**

The commissioner expects that all providers will deliver high quality tissue viability care to all patients and follow current national guidance regarding pressure ulcer prevention. Care home providers are expected to be able to provide general wound care including the treatment of pressure ulcers and leg ulcer management.

**Providers will:**

- Assess and monitor all residents to determine the risk of developing pressure ulcers via a risk assessment on admission to their care and on a regular basis depending on their level of mobility and risk to reduce the risk of developing pressure ulcers.
Operating standards for care homes  
May 2017

- Ensure that care staff undertakes a skin assessment and act on issues identified and provide a patient specific care plan.
- Use skin bundles in collaboration with the local tissue viability service.
- Ensure that their staff attends relevant training and education sessions in order to identify and assess residents at high risk of developing pressure ulcers. This training to include the MUST, continence management and frailty score.
- Ensure that a clinical assessment and treatment plan will precede the provision of any equipment or treatment.
- Ensure every effort is taken to facilitate easy access to pressure relieving equipment.
- Develop excellence in preventative strategies, including appropriate equipment for the prevention of pressure ulcers.
- Have a link/resource nurse for tissue viability.
- Carry out skin care regimes in line with current tissue viability advice.
- Implement the treatment plan.
- Refer all grade three and four pressure ulcers to tissue viability, and report to CQC and NHS Kernow clinical governance lead.
- All patients with leg ulcers should have a leg ulcer assessment and have leg ulcer treatment commenced depending on the results of this.
- All nurses applying compression treatment must attend leg ulcer training and be assessed as competent to apply safely.
- All wounds should be assessed and evaluated using a recognised assessment and evaluation template.
- All dressings should be applied in line with the Cornwall Joint Formulary.

Quality indicators
- Residents assessed at high risk of developing pressure ulcers have a patient specific care plan that outlines preventative strategies.
- Staff attend pressure ulcer training and wound care training at induction.
- All care homes have tissue viability link nurses and attend pressure ulcer reduction group.
4. Continence care

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<tr>
<td>Continence care</td>
<td>Sharon Eustice</td>
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**Topic overview**

Urinary incontinence is one of the leading causes for admission into care homes. The scope of the problem is significant, the costs are high and there is no convincing evidence of lasting change for sufferers of this problem in care homes. However, incontinence is very treatable. Prevalence studies have indicated an association between ageing and urinary incontinence. Estimates of prevalence range between 31 per cent to over 70 per cent in both community and institutional settings. Reasons for developing standards include:

- National prevalence figures suggest that two out of every three people who live in care homes are incontinent;
- Residents who have been identified as incontinent should have access to assessment, treatment and management of their problem as per national and local guidelines;
- Local surveys suggest that there is considerable variation in the management of incontinence in care homes;
- Care homes which state they are able to provide services for people with incontinence should be able to demonstrate this; and
- The need for education and training of staff in the assessment and management of incontinence, particularly where there are long-term conditions such as dementia, stroke, diabetes or frailty.

The preservation of privacy and dignity during continence care is an essential feature of care delivery.

**Commissioner requirements**

The commissioner expects that all providers will ensure that they deliver high quality continence care to all patients and follow current local and national guidance; and that bladder or bowel continence problems are identified and reversible causes treated, with the aim to restore continence by implementing assessment and therapeutic treatment.

**Providers will:**

- Screen the resident for bladder and bowel continence problems by asking a trigger question (e.g. are you bothered by your bladder or bowel?).
- Identify and treat reversible causes of bladder and bowel dysfunction, with the aim to restore continence by implementing assessment and therapeutic treatment.
- Implement clinical assessment and a treatment plan, which will precede the provision of absorbent hygiene products.
Operating standards for care homes
May 2017

- Use indwelling urinary catheters only as a last resort with the aim of removing the catheter as soon as possible.
- Participate in education to identify and assess residents with bladder and bowel symptoms.
- Nominate a link/resource nurse for the promotion of continence.
- Use care pathways in collaboration with the local bladder and bowel specialist service.
- Facilitate easy access to toilet facilities.

Quality indicators
All residents are asked on admission if they are bothered by their bladder or bowel and a clinical assessment is undertaken for those who have a continence problem.

Supporting Information
- Bladder and Bowel UK (2016): [www.bladderandboweluk.co.uk](http://www.bladderandboweluk.co.uk)
• Shaw C and Wagg A (2017) Urinary incontinence in older adults. Medicine in Older Adults Volume 45, Issue 1, Pages 23–27
Operating standards for care homes  
May 2017

5. Infection prevention

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<tr>
<th>Standard</th>
<th>Author</th>
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<tr>
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<td>Lisa Johnson</td>
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**Topic overview**

The steps taken in care homes to protect residents and staff from infection represent an important element in the quality of care, particularly as some infections have the capacity to spread within environments where susceptible people share eating and living accommodation. It is also important to be aware of the possibility of infection in residents and for care workers to identify these promptly.

**Commissioner requirements**

The commissioner expects that providers will comply with the requirements set out in the documents indicated at the end of this operating standard and be able to provide evidence to that effect. In doing so, residents and staff will be protected from avoidable infections.

**Providers will:**

All good practice interventions are encompassed within hygiene code compliance. The following list reflects best practice which could be assessed by observation or questioning:

- All staff are trained to understand infection prevention responsibilities of their individual role;
- Previous infection and risk of infection should be assessed and documented for each resident;
- Care plans should reflect infection status and specify best practice relating to any invasive devices;
- Staff providing personal care must be bare below the elbows, have short nails without nail varnish and not wear any rings other than a plain band;
- Work-wear must be clean on each shift and of material that can withstand high temperature laundering;
- Hand hygiene performed according to the World Health Organisation (WHO) ‘Five moments’¹; and
- Adequate protective clothing must be available and used appropriately according to risk of procedure;
- Equipment and environment are cleaned/disinfected according to policy;
  - Medical devices must be stored to avoid contamination;
  - Laundry is handled, stored and cleaned appropriately to minimise contamination of staff, equipment and environment;
  - Sharps are safely disposed of in correct containers;

¹ [http://www.who.int/gpsc/5may/tools/workplace_reminders/en/](http://www.who.int/gpsc/5may/tools/workplace_reminders/en/)
- Waste is correctly segregated in colour coded bags and stored in a locked area before collection;
- Laboratory specimens are collected appropriately, (using aseptic technique where required) stored safely before collection;
- Specimen results are recorded to detect patterns, clusters or outbreaks; and
- Antimicrobial medication is reviewed regularly and complies with local guidance.

Quality indicators

<table>
<thead>
<tr>
<th>Quality requirement</th>
<th>Method of measurement</th>
</tr>
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<tbody>
<tr>
<td>Staff are seen to be bare below the elbows</td>
<td>Observation</td>
</tr>
<tr>
<td>Equipment is visibly clean and free from dust.</td>
<td>Observation</td>
</tr>
<tr>
<td>A named lead for infection prevention is identified.</td>
<td>Documentation and evidence of activity.</td>
</tr>
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Supporting information

- The Care Quality Commission (CQC) - page 43 (12(2)h):
  [http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf](http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf)
- Providers are referred to the hygiene code for guidance:
- A common source of information on the prevention and control of infection in Care Homes was published in February 2013:
- NICE guidance:
  - [http://www.nice.org.uk/guidance/gs61/chapter/list-of-quality-statements](http://www.nice.org.uk/guidance/gs61/chapter/list-of-quality-statements)
  - [https://www.nice.org.uk/guidance/cg139/chapter/1-Guidance](https://www.nice.org.uk/guidance/cg139/chapter/1-Guidance)
Operating standards for care homes
May 2017

Royal Cornwall Hospitals NHS Trust

Care Home UTI Management Tool for persons >65

Care home suspects a resident has a UTI and has ruled out other sources of infection
(see reference sheet)

<table>
<thead>
<tr>
<th>NEW ONSET Symptoms</th>
<th>What does this mean?</th>
<th>Tick if present</th>
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<tbody>
<tr>
<td>Dysuria</td>
<td>Pain on urinating</td>
<td></td>
</tr>
<tr>
<td>Urgency</td>
<td>Need to pass urine urgently/new incontinence</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>Need to urinate more often than usual</td>
<td></td>
</tr>
<tr>
<td>Suprapubic tenderness</td>
<td>Pain in lower tummy/above pubic area</td>
<td></td>
</tr>
<tr>
<td>Haematuria</td>
<td>Blood in urine</td>
<td></td>
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<tr>
<td>Polyuria</td>
<td>Passing bigger volumes of urine than usual</td>
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<tr>
<td>Lein pain</td>
<td>Lower back pain</td>
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<tr>
<td>Delirium</td>
<td>Confusion - new onset or worsening of pre-existing</td>
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2 or more symptoms - UTI LIKELY
Please record vital signs

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Result</th>
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<tbody>
<tr>
<td>Temperature</td>
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<tr>
<td>Heart Rate</td>
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<td>Respiratory rate</td>
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<td>Blood glucose</td>
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<td>Blood taken?</td>
<td>WCC: CRP:</td>
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<tr>
<td>Catheter</td>
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Less than 2 symptoms (or 1 if urinary catheter)-
UTI UNLIKELY:
- Observe,
- Manage symptoms
- Encourage fluid intake

Action Plan
Done

- Phone GP: state symptoms and vital signs
- Collect Mid Stream Urine specimen and send to microbiology lab
- Fax this tool to GP
- Name/ sign/ designation Date/ Time

GP Management Decision

- Face to face review by GP undertaken?
  (If YES then GP to complete below, IF NO then carer to complete based on conversation with GP)

DIAGNOSIS
- Lower UTI
- Pyelonephritis
- Currently not clear. Await MSU & monitor patients symptoms
- Other

PLAN (tick all that apply)
- Review in 24 hours
- Mid Stream Urine specimen (MSU)
- Antibiotics prescribed & details
- Other

Sign & print: Date
Designation:
Management pathway for when care home suspects UTI
(Simplified guidelines from SIGN 88)

Does the patient have any symptoms that could indicate another source of infection?
(Respiratory, Gastrointestinal, Skin/Soft Tissue)

Yes
Manage symptoms and discuss with G.P

No

Does the patient have 2 or more symptoms on the algorithm? (1 or more if catheterised)

No
Observe, conservative management, encourage fluids

Yes
Manage dl's comfort and temperature, send a sample for culture, discuss with G.P

NB – if in doubt or any concerns discuss with G.P

---

URINE CULTURE IN WOMEN AND MEN > 65 YEARS

- Only send urine for culture if two or more signs of infection, especially dysuria, fever > 38°C or new incontinence.
- **Do not treat asymptomatic bacteriuria** in the elderly as it is very common.
- Treating does not reduce mortality or prevent symptomatic episodes, but increases side effects & antibiotic resistance.

---

URINE CULTURE IN WOMEN AND MEN WITH CATHETERS

- **Do not treat asymptomatic bacteriuria** in those with indwelling catheters, as bacteriuria is very common and antibiotics increase side effects and antibiotic resistance.
- Treatment does not reduce mortality or prevent symptomatic episodes, but increase side effects & antibiotic resistance.
- Only send urine for culture in catheterised if features of systemic infection. However, always:
  - Exclude other sources of infection.
  - Check that the catheter drains correctly and is not blocked.
  - Consider need for continued catheterisation.
  - If the catheter has been in place for more than 7 days, consider changing it before/when starting antibiotic treatment.
- **Do not give antibiotic prophylaxis for catheter changes unless history of symptomatic UTIs due to catheter change.**
- Face to face review between patient and prescribing clinicians is NICE Quality Standard when diagnosing a UTI (UTI’s in adults Q590, June 2015)

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6. Dementia care

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<tr>
<td>Dementia care</td>
<td>Jodie Ley</td>
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**Topic overview**

The Department of Health (2015) describe the term ‘dementia’ as a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. In 2015 data published by the Alzheimer’s Society, suggests there are 850,000 people living with dementia in the UK, 84,413 of these people live in the South West and approximately 33 per cent of these people reside within residential care.

There are approximately 416,000 people living in care homes in the UK (Laing and Buisson survey 2016). This is four per cent of the population aged 65 years and over, rising to 16 per cent of those aged 85 or more. Cornwall currently has an approximate population of 536,000 (Cornwall Council, 2011) 129,100 are aged over 65 years, 24 per cent of our population. 4,104 (Cornwall Council 2015) people live in a care home setting with Cornwall having 5,478 care home beds in the county. There is a high prevalence of cognitive impairment and polypharmacy (NHS, 2016). This affects how care can, and should be delivered. In contrast, 40 per cent of people over the age of 65 occupying a hospital bed will be living with dementia (Alzheimer’s Society, 2014). Residents of care homes have high levels of complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty. Furthermore these vulnerable individuals also have high rates of both primary care consultation and hospital admission. Learning from the work of the Gateshead Care Home vanguard we know that 80 per cent of people seen in this site area were living with a mental health issue of some kind.

People living with dementia can experience a variety of diverse symptoms, which may provide challenges during the delivery of care. For this reason it is it is essential that care homes have the knowledge and skills of physical disability or access to those that can support them to meet the needs of such illness. Furthermore co-morbidities can add to the challenge of empowering people with dementia and delivering excellent person-centred care as described by Kitwood (1995).

In 2009 the Government committed to making dementia a national priority with the publishing of the Dementia Strategy and revised Dementia strategy in 2013. More recently we have seen the government’s commitment with the development of the Prime Minsters Challenge on Dementia 2020.

The Dementia Strategy (2013) advocates the importance of care settings being responsive to individual needs, providing people with choice, the ability to make decisions about their care and providing personalised care. Recommendations state that settings should formulate non-pharmacological interventions, for what they term behavioural disorders in dementia, to avoid using medical alternatives, such as anti-
psychotic medication. Suggesting people with dementia have access to individual purposeful activities, rather than general entertainment.

A continual drive to improve the quality of care received by people living with dementia is maintained by the development of the National Institute for Health and Care Excellence Quality Standards (NICE, 2013). Providing standards to ensure health and social care providers provide measurable quality improvements within a particular area of health or care.

The care provided in care homes is underpinned by the basic requirement of knowledge based care through quality training in this area, also a requirement of The Dementia Competency Framework DoH (2011), furthermore the Care Quality Commission sets out basic standards that are expected within care environments and monitors homes.

With such legislation and guidelines in place to support people living with dementia and the care environment they are in, it is vital that a sound working knowledge underpinned by theory be demonstrated in the area of dementia care.

**Commissioner requirements**

In order to achieve Gold Standard quality of care:

- A workforce equipped with a comprehensive working understanding of the often complex needs of those living with dementia together with an awareness of how to interoperate a person’s bio-psychosocial experiences of living with dementia and how these can impact on both mental and physical wellbeing;
- To provide person centred, individualised care that reflects the ever changing and often challenging needs of the individual through robust risk and care planning;
- To maintain the rights of individuals through having an up to date working knowledge of The Mental Capacity Act (2005) to include Deprivation of liberty Safeguards (DoL’s), The Mental Health Act (2007) and how these issues may impact on care; and
- To provide a professional service within a safe and happy environment that is conducive in promoting the wellbeing and meeting the needs of the individual.

**Providers will:**

- Ensure staff are trained in and clearly understand how to provide person centred, individualised care planning. This may include The Newcastle Model (James, 2011). The Newcastle model, as described by James (2007) is a framework featuring a bio-psychosocial approach for treating what James terms ‘behaviours that challenge’, with people with dementia, who live in a care setting.
- Ensure staff have a proactive approach to medication management whilst being able to identify promptly when to seek advice. Liaising with their community pharmacist to conduct regular reviews of all residents’ medication, considering poly-pharmacy. This maybe in conjunction with other healthcare professionals such as the DLN’s or community matron;
- Demonstrate a strong working relationship with relatives and carers, GPs and secondary services as necessary;
Have a sound working knowledge of The Mental Capacity Act, some knowledge of the Mental Health Act and a robust understanding of the implications of Deprivation of liberty Safeguards;

Provide individualised meaningful activities, advocating a person’s personal interests; and

Tools have been devised in Cornwall to assist in the education of staff and support them within their work in care homes as follows:
- Dementia End of Life Pathway (2012);
- AMP (Asses, Monitor, Prevent); and
- STAR (Stop, Think, Assess, Review).

Quality indicators

The home provides person centred care that reflects the changing needs of the individual.

The home has relevant tools to support them in their work.

Supporting information

7. Parkinson’s and the management of acute deterioration of symptoms

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<th>Standard</th>
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<td>Parkinson’s and the management of acute deterioration of symptoms</td>
<td>Lynne Osborne</td>
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**Topic overview**

Throughout the disease progression it is known that Parkinson’s symptoms can significantly worsen, this is not always related to a change in medication. Most commonly Parkinson’s disease symptoms deteriorate when infection is present for example urinary tract and chest infections, wounds and infected rashes. Symptoms may also deteriorate when constipation is unmanaged or if Parkinson’s medication is not taken on time every time.

There are a higher number of people with Parkinson’s disease admitted to hospital in Cornwall resulting from urinary tract / chest infections, falls and cognitive impairment (Neurowatch Data Profile 2013). People with Parkinson’s also have a longer than average hospital admission in Cornwall (Neurowatch Data Profile 2013) and previous audit findings of patient experiences during hospital admission has been variable (Peninsula Community Health 2012).

In terms of reducing hospital admissions the acute deterioration pathway overleaf has been developed by the Parkinson’s team. It is suggested this pathway will provide guidance regarding the management of people with Parkinson’s within the care home environment if symptoms acutely deteriorate.

**Commissioner requirements**

The commissioner expects that all providers will ensure that they deliver high quality care to people with Parkinson’s, ensuring that where appropriate medication is self-administered and given on time every time. Parkinson’s medications are listed as critical medication. The commissioner expects all providers to familiarise themselves with the acute deterioration pathway.

**Providers will:**

- Ensure that all residents with Parkinson’s receive their medication on time every time. Parkinson’s symptoms can fluctuate over the course of the day.
- Ensure that residents have an adequate fluid intake to reduce the likelihood of urinary tract infections.
- Ensure that residents with Parkinson’s do not become constipated. The medication of choice is often Macrogol (laxido).
- Ensure that the person with Parkinson’s is able to swallow their medication /food / fluid without any difficulties. If problems taking the prescribed medicines are encountered, please seek advice from the Parkinson’s specialist team. Oral
medicines should not be routinely switched to unlicensed liquid preparations as the change could adversely affect the person’s condition. If there is a swallow difficulty a speech and language therapy referral may be required.

- If a recent medication change has been made and the symptoms appears to be clinically worse contact the Parkinson’s specialist team for advice.
- Rule out the following if a residents Parkinson’s symptoms \(^2\) acutely deteriorate:
  - An underlying UTI as per pathway;
  - An underlying chest infection;
  - Wounds /rashes for signs of infection;
  - Constipation; and
  - Is the resident taking their medication as prescribed?
- Contact the Parkinson’s team for advice if a residents Parkinson’s symptoms acutely deteriorate and all the above measures have been followed via email on pdnurses.cornwall@nhs.net or telephone 01209 318 048.

Quality indicators

- All residents with Parkinson’s disease receive their medication on time every time.

\(^2\) Parkinson’s symptoms include: tremor, slowness, stiffness, gait change ie shuffling / freezing, impaired balance, falls, dyskinesia, anxiety, depression, hallucinations, and confusion.
Operating standards for care homes
May 2017

Please ensure you complete all 4 steps

1. Is infection present/blood abnormalities?
   NB: PD patients do not always display signs of infections therefore please consider carrying out the tests below:
   1) Urinalysis if positive send to microbiology
   2) Blood tests inc FBC, U&E, CRP, TFTs (thyroid imbalance can worsen PD)
   3) Examine chest
   4) Any wounds, infected rashes?

   Positive infection screen:
   Once treated patient should return to their normal level of functioning

2. Is the patient constipated?
   Bowels opened within the last 2 days (or consistent with patient’s normal bowel habit)

   Constipation present:
   Treat accordingly (NB: laxative of choice in PD is Macrogol (Laxido) but choice of laxative depends on individual patient

3. Has the patient been prescribed any new medications within the last month?

   YES
   NO

3a. Is it one of the medications listed overleaf?

   YES
   NO

   YES
   NO

   Consider simplifying the drug regimen if possible in conjunction with PD nurse. Also refer to community pharmacist or GP dispensary for assessment under DDA if necessary

4. Is the patient taking their medications as prescribed? (Correct doses and times)

   YES
   NO

Refer to Parkinson’s Nurse 01209 318 048
8. Use of medical devices

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<th>Standard</th>
<th>Author</th>
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<tr>
<td>Use of medical devices</td>
<td>Heather Newton</td>
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**Topic overview**

A medical device is an instrument, apparatus, implant, in vitro reagent or similar that is used to diagnose, prevent or treat disease or other conditions. It does not achieve its purpose through chemical reaction within or on the body. Medical devices vary in complexity and application and range from a medical thermometer or disposable gloves to larger electro mechanical equipment such as patient hoists.

Care homes are required to ensure that the procurement, maintenance, use and storage of medical devices comply with national standards (MHRA and CQC). Clinical staff within care homes must be competent in the safe use and storage of medical devices.

The risk of not managing medical devices correctly has been recognised by the Care Quality Commission Essential Standards of Quality and Safety Outcome 11 which refers to the safety, availability and suitability of equipment. People should be safe from harm from unsafe or unsuitable equipment.

**Commissioner requirements**

The commissioner expects that care homes will manage all of the elements relating to medical device management in the home in such a way as to ensure that people and staff remain safe from harm.

**Providers will:**

- Have a robust process for the procurement of medical devices to ensure that it meets with all regulatory standards.
- Have a robust process for the installation and on-going maintenance of relevant medical devices demonstrating evidence of safety checks where appropriate.
- Ensure that all medical devices are stored safely and securely to prevent theft, damage or misuse.
- Ensure that medical devices are disposed of or recycled safely and securely. Modifications should only take place in line with manufacturer’s instructions.
- Have clear procedures in place for the safe use of medical devices. This should include the availability of medical device product guidance.
- Ensure that where equipment is provided as part of regulated activity, risks are assessed, monitored and reviewed.
- Ensure that the type and range of equipment used in the care home promotes independence, comfort, privacy and dignity and that equipment is available to service users when required.
• Ensure that medical devices are only used for the purpose to which they have been deemed suitable by the manufacturer. Items deemed for single use and single patient use must be used according to manufacturer’s guidance.

• Ensure that competency based training programmes are in place for the safe use of medical devices. Staff should only use medical devices once they know how to use and operate them correctly.

• Have arrangements in place for reporting of adverse events, incidents, errors and near miss reporting related to medical devices in a timely manner. Outcome reporting should promote opportunities for shared learning.

• Have in place contingency plans for the use of medical devices if there is a failure of essential services such as electricity and water.

Quality indicators
• The home has clear procedures in place for the safe use of medical devices.

Supporting information

9. Long term conditions and frailty case management

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<th>Standard</th>
<th>Author</th>
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<tr>
<td>Long term conditions and frailty case management</td>
<td>Marie Prior</td>
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Topic overview
In England today 60 per cent of adults report a chronic health problem and 8.8 million have a long term condition that severely limits their day to day ability to cope. Multiple long term conditions make care particularly complex, and a small number of patients and diseases account for a disproportionate amount of health care use.

Residents of Care Homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty (BGS, 2011). A study undertaken to compare the quality of chronic disease care for older people in care homes with that undertaken in the community (Shah et al 2011) identified that there is scope for improving the management of chronic diseases in care homes, and that attainment of quality indicators was significantly lower for residents of care homes than for those in the community.

Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, chronic obstructive pulmonary disease, angina, epilepsy and hypertension. Actively managing patients with ACS conditions - through vaccination; pro-active disease-management or case-management; prevents acute exacerbations and reduces the need for emergency hospital admission (The Kings Fund, 2011).

Commissioner requirements
The commissioner expects that providers will comply with the requirements of case management, including pro-active identification of early deterioration, action to effectively and promptly manage any acute events, and to be able to provide evidence to that effect. In doing so, residents and staff will be protected from deterioration and harm.

Providers will:
- Ensure that their workforce have acquired or are supported to acquire the relevant knowledge, skills and competencies to enable them to effectively manage residents with long term conditions and frailty and to ensure an informed and confident care service.
- Ensure that condition specific care plans are implemented to support evidence based care and proactive case management. Care plans will reflect the management of individual long term conditions and identify the actions that need to be undertaken by the registered nurse and/or care worker.
Operating standards for care homes
May 2017

- Clinical staff identify frailty and implement strategies to ensure that effective and consistent management of symptoms or disability and act promptly on any deterioration or changes.
- Review whether interventions to manage symptoms are effective for the individual and discuss with GP or specialist service as necessary.
- Monitor the condition of individuals and take appropriate action to remedy any problems or adverse effects.
- Evaluate and analyse all acute hospital admissions from the home and identify actions to reduce re-occurrence.

Quality indicators
- Clinical staff in the home are trained and have evidence to show how to identify frailty, new symptoms, changes in existing symptoms, holistic assessment, recognition of aggravating factors and deterioration and to be able to instigate prompt action to support the treatment and management of long term conditions, frailty and complex care.
10. Care planning and record keeping

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<th>Author</th>
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<tr>
<td>Care planning and record keeping</td>
<td>Jo Dolton</td>
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**Topic overview**

Good care planning and record keeping is an integral part of nursing practice, and is essential to the provision of safe and effective care.

**Commissioner requirements**

It is expected that all providers delivering residential or nursing care, will ensure that they deliver on their ‘core responsibility to provide safe, effective and high quality care’ (statement of government policy on adult safeguarding May 2013) to all people residing and receiving care in their establishment. Individuality and person centred care planning and effective record keeping is at the core of this requirement.

**Providers will:**

- Ensure that all nursing staff are aware and understand the NMC professional code of practice, and are aware of the NMC guidance on record keeping.
- Provide training to ensure that all nursing staff are competent in the understanding of how to formulate, action and evaluate a care plan and produce effective care records.
- Provide training to ensure that all care staff understand the components and the reasoning for care plans to deliver effective safe care and the need to produce effective care records.
- Provide clear guidance/standards to all nursing and care staff in the delivery of effective individualised (personalised) care planning and promoting empowerment for the person whose care is being devised.
- Ensure that care plans address all care domains appropriately.
- Ensure that within supervision processes, care planning and effective record keeping is discussed, and competence is assessed.
- Utilise the care plan guidance provided by NHS Kernow.

**Quality indicators**

- Evidence of staff competence in planning, implementing and evaluating care.
- Staff meet NMC guidance on record keeping.
11. Dignity and respect

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<th>Standard</th>
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<tr>
<td>Dignity and respect</td>
<td>Nicky Oxley</td>
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Date  Review date
May 2017  May 2018

**Topic overview**
The principles on which the home’s philosophy of care is based must be the ones which ensure that residents are treated with respect, that their dignity is preserved at all times, and that their right to privacy is always observed.

**Commissioner requirements**
In meeting a key foundation of dignified care the commissioner requires all care staff to adopt the concept of ‘always events’ for delivering dignity in care, that is:

**Always:**
- Treat those in your care as they wish to be treated, with respect, dignity and courtesy;
- Remember the resident’s nutrition and hydration needs;
- Encourage formal and informal feedback from older people and their relatives, carers and advocates, to improve practice;
- Challenge poor practice at the time and learn as a team from the error; and
- Report poor practice where appropriate, the people in your care have rights and you have professional responsibilities.

**Providers will:**
- Give guidance to all their staff on treating residents with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
- Train and assess staff competency in relevant communication skills including their ability to communicate warmth and kindness.
- Ensure residents are introduced to all healthcare professionals involved in their care and that staff use the term of address preferred by the resident.
- Ensure that every resident has a care plan that identifies their own wishes, preferences and priorities and addresses the support they need to retain and develop their sense of dignity and personal identity.
- Ensure care plans evidence that respect is shown for residents’ cultural background, gender, age, sexuality, religion or belief and disability if applicable.
- Actively involve residents in shared decision making and support them to make fully informed choices about investigations, treatment and care.
- Respect and review residents’ preferences for sharing information with partners, family members and/or carers:
  - Ensure care plans are kept up to date as the residents circumstances change;
  - Ensure that when delivering personal care such as nursing, bathing, washing and assisting the resident using the toilet that the resident’ privacy and dignity are respected at all times;
- Do their best to develop an ‘enriched environment for residents, family and friends. This will include access to meaningful activity;
- Ensure residents have easy access to a telephone for use in private; and
- Ensure residents wear their own clothes at all times.

Quality indicators
There is evidence in the home that residents' wishes, preferences, priorities and beliefs are taken into account.

Supporting Information
- ‘Always events’ Institute of Healthcare Improvement.
- Patient experience in adult NHS services: Improving the experiences of care for people using adult NHS Services. NICE Guideline 138:
  http://www.guidance.nice.org.uk/cg138
12. Clinical supervision

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**Topic overview**

Supervision is a “formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection” (DOH1993).

Supervision assists in developing a positive culture in a provider and focuses on continuous improvement and consistent practice helping to improve outcomes for vulnerable people.

**Commissioner requirements**

The commissioner expects that all providers delivering residential or nursing care, will ensure that they deliver on their ‘core responsibility to provide safe, effective and high quality care’ (statement of government policy on adult safeguarding May 2013) to all people residing and receiving care in their establishment. Clinical supervision is integral in this process and it is expected that formal supervision is embedded into every employees working life (supported by NMC Standards of conduct, performance and ethics for nurses and midwives).

**Providers will:**

- Understand and promote a culture that clinical supervision will assist in supporting person centred and safeguarding standards of care whilst supporting growth and professional development for the clinician /carer.
- Ensure an appropriate framework for clinical supervision is in place for all staff taking into account and delivering on diversity within the workforce. To include:
  - Focus on patient care;
  - Reflection on clinical practice and safeguarding principles:
    - Empowerment: Presumption of person led decisions and informed consent.
    - Prevention: It is better to take action before harm occurs.
    - Proportionality: Support and representation for those in greatest need.
    - Partnership: Detecting and reporting neglect and abuse.
  - Process of learning by supervisee (e.g. how learning is embedded into the workplace to improve outcomes for people using the service);
  - Professional support for the supervisee; and
  - Championing the importance of clinical supervision at all levels.
- Ensure provision of training and development for clinical staff to enable them to act in a supervisory capacity:
  - The identification and training of individuals who could facilitate group/ peer supervision;
- Ensuring staff have the opportunity to share learning outside their teams or individual sessions if they feel others may benefit from their experiences;
- Linking systems of clinical supervision to clinical governance, Appraisal and Revalidation;
- Ensuring clinical supervision is supported and that clinical staff have sufficient protected time to access appropriate supervision;
- Ensuring appropriate records of supervision are kept; and
- Ensuring a reference to supervision is included in all recruitment processes.

**Quality indicators**
- An appropriate framework for clinical supervision is used in the home.
13. Safeguarding adults

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<td>Safeguarding adults</td>
<td>Chris Parish</td>
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**Topic overview**

Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure the adults wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Organisations must always promote the adults wellbeing in their safeguarding arrangements. Safeguarding is not a substitute for provider’s responsibilities to provide safe high quality care and support (Care Act 2014).

**Commissioner requirements**

The commissioner expects that providers will comply with the requirement of safeguarding adults, including the pro-active identification of abuse and neglect and the appropriate implementation of the local safeguarding adults’ procedures, from raising alerts to attendance at meetings and full co-operation with the process, working with the local authority quality assurance team, NHS Kernow safeguarding adults leads and the continuing healthcare team where necessary.

**Providers will:**

- Ensure that their workforce have acquired or are supported to acquire the relevant level of safeguarding adults training. To include mental capacity act, deprivation of liberty, safeguarding adults and human rights.
- Ensure that they have in place comprehensive safeguarding adults policies and procedures that are integrated to the local safeguarding adults’ boards’ policies and procedures. To include whistle blowing policy.
- Ensure that all staff act at all times in a manner that promotes the dignity and respect of all residents.
- Ensure that all staff know how to recognise abuse and neglect and are aware of how to raise a safeguarding adult’s alert.
- Ensure that robust, regular clinical supervision is in place for all staff.
- Ensure that records are kept of all safeguarding alerts raised regarding the home and their outcomes.

**Quality indicators**

- All staff know how to recognise and prevent abuse and neglect and are aware of how to raise a safeguarding adults alert and how to ensure an individual is kept safe.
14. Incident reporting

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<td>Incident reporting</td>
<td>Richard Askew</td>
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**Topic overview**

It is important that safety incidents that could have or did harm a patient or client receiving NHS funded care are reported so they can be learnt from and any necessary action can be taken to prevent similar incidents from occurring in the future. Learning from incidents can only be achieved if they are routinely reported and shared, so all providers of NHS funded care need to have local incident reporting systems in place and should encourage their staff to use them.

**Commissioner requirements**

When an incident occurs that could have or did harm a patient or client it must be recorded on a local reporting system. The record should identify, as a minimum, what happened, to whom (preserving confidentiality), when and how the incident occurred with actions taken to ensure or restore the safety of all individuals affected and subsequent actions taken to prevent similar incidents occurring in future.

Patient safety can be categorised using these topic headings:

- Abuse/aggression;
- Consent, communication, confidentiality;
- Documentation (including checklists/patient records);
- Environment (including cleaning);
- Human factors and patient safety culture (including, teamwork, staffing);
- Medical devices/equipment;
- Medication safety;
- Patient accident (including slips, trips and falls);
- Patient admission, transfer, discharge (including patient ID);
- Patient assessment and diagnosis (including tests);
- Patient treatment/procedure (including nutrition); and
- Risk assessment and patient safety.

**Providers will:**

- Ensure there is a system in place to record safety incidents
- Ensure staff are aware of the need to report safety incidents and the systems in place
- Ensure all safety incidents are recorded and that any incidents requiring external reporting (such as RIDDOR, CQC, serious incidents requiring investigation) are identified and reported appropriately
- Take action immediately following any incident to ensure the safety of all those affected is restored and maintained, and to ensure the safety of others who are not immediately affected is not compromised
Follow up all incidents with appropriate measures to prevent similar incidents happening again
Inform patients about safety incidents that affect them

Quality indicators
- There is evidence that all incidents are reported and recorded and actions taken as applicable.

Supporting information
- Safety first: a report for patients, clinicians and healthcare managers
  Department of Health, published December 2006
- NHS England website: Reporting patient safety incidents:
15. Incident reporting

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<th>Standard</th>
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<tr>
<td>Serious incidents</td>
<td>Richard Askew</td>
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**Topic overview**

A serious incident is an incident that results in one or more of the following:

- Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- A ‘never event’ - as defined in the never events ‘policy framework for use in the NHS’;
- A scenario that prevents, or threatens to prevent, an organisation’s ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- Allegations, or incidents, of physical abuse and sexual assault or abuse; and
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

If a serious incident occurs during NHS funded care (including in the community), national guidelines require a thorough investigation to be undertaken. Serious incidents are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again.

**Commissioner requirements**

When an incident occurs that fits, or appears to fit, the criteria for a serious incident it must be reported to the clinical governance lead at NHS Kernow, the commissioner and all other relevant bodies. The commissioner expects providers to meet the requirements of NHS Kernow policy and procedure for reporting and learning from serious incidents requiring investigation.

**Providers will:**

- Report serious incidents within two working days of discovery.
- Collaborate with investigations and any remedial work required following investigations.
- Keep records of serious incidents including data on the numbers and types of incidents, excluding material that would compromise patient confidentiality.
- Comply with national requirements and guidance in relation to being open with patients or their representatives when things have gone wrong.
- Provide relevant guidance and training for staff to help them identify and report incidents.
Operating standards for care homes
May 2017

- Ensure that action plans are implemented.

Quality indicators
- Staff understand what is meant by the term serious incident, and how and to whom these should be reported.

Supporting information
- NHS Kernow Policy and Procedure for Reporting and Learning from Serious Incidents Requiring Investigation: [http://intra.cornwall.nhs.uk/GET/d10284973](http://intra.cornwall.nhs.uk/GET/d10284973)
16. Human resources

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<td>Human resources</td>
<td>Jayne Marsh</td>
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**Topic overview**

Reasons for developing these standards are to ensure:

- Recruitment and selection is fair and effective;
- Professional Standards are maintained;
- Managers are competent, and employees are appropriately trained and developed;
- Equality is central to policies, procedures, and ways of working;
- Policies are clear and communicated;
- The importance of health at work is recognised; and
- Legal obligations are understood and adhered to.

**Commissioner requirements**

It is expected that providers will support their staff to be competent and confident in delivering and evidencing the key requirements set out in this standard; and to comply with the legal requirements of employing people.

**Providers will:**

- Ensure recruitment and selection is fair and non-discriminatory to include clear job descriptions and person specifications, at least two people on interview panels to prevent bias, and records of the interviews are kept.
- Check references (ideally two professional references from the most recent employer(s) covering a period of at least three years), qualifications, and entitlement to work in the UK; and carry out Disclosure and Barring Service (DBS) checks for relevant roles, before commencing employment.
- Provide a comprehensive induction for staff.
- Issue all employees with a contract of employment.
- Meet the legal requirements of minimum wage and equal pay.
- Allow employees to take proper breaks in line with the working time regulations, and use their full annual leave entitlement.
- Hold formal appraisals, and use them to provide the basis for making development and improvement plans.
- Have supervisory or peer support arrangements in place.
- Ensure disciplinary and grievance procedures follow ACAS code of practice (tribunals take this into account), make employees aware of your procedures and expectations, and monitor and review these procedures.
- Have clear policies to prevent unacceptable behaviour at work: equality and diversity policy/bullying and harassment policy. Make employees aware of the requirements and standards set out in these policies.
• Ensure nurses and other qualified employees maintain their professional competence and minimum levels of qualifications.
• Ensure all employees are competent and have the required qualifications, knowledge, skills and experience to carry out their role. Provide the required training and development as needed.
• Ensure employees are registered with the relevant professional regulator or body when necessary and are allowed to work by that body.
• Ensure professional registration is current, kept up to date and monitored to prevent lapses in line with nurse revalidation standards.
• Refer staff that are thought to be no longer fit to work in health and adult social care, and meet the requirement for referral, to the appropriate bodies.
• Ensure staffing levels are appropriate and there are systems in place to monitor and cover when staffing levels are affected by absence and emergency.
• Assess the skill mix of the organisation and take measures to address any imbalances.
• Process all employee data in line with the Data Protection Act.

Quality indicators
• The workforce has the required skills, competencies and support to be effective, and operates within the appropriate legal frameworks for employing people.

Supporting information
• Advisory, Conciliation and Arbitration Service: www.acas.org.uk
• GOV.UK: www.gov.uk (Employing People section)
17. Managing complaints

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<td>Managing complaints</td>
<td>Jayna Chapman</td>
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**Topic overview**
The law requires a complaints procedure to be in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf. This should be in line with the requirements of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

**Commissioner requirements**
The commissioner expects all patients to have knowledge and information about the complaints procedure and to be able to use it without fear that their care may be compromised as a result of making a complaint.

The commissioner expects the provider to monitor complaints and positive feedback from service users, and to provide evidence that learning and improvements result from this.

**Providers will:**
- Provide information about the complaints procedure to all residents, in formats that are appropriate to their individual needs.
- Provide information and contact details of appropriate complaints advocacy.
- Have appropriate procedures in place for handling complaints.
- Ensure that any complaint is fully investigated, and as far as practicable, resolved to the complainant’s satisfaction.
- Be able to demonstrate a learning culture by showing examples of changes which have been made as a result of complaints.
- Be able to produce, upon request, evidence of complaints made and responses and action taken.

**Quality indicators**
- The home has appropriate procedures in place for handling complaints.
18. Whistleblowing

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<td>Whistleblowing</td>
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**Topic overview**
The process by which a member of staff can raise a concern about a possible risk, wrong-doing or malpractice that has a public interest aspect to it. The provider is expected to engender a culture which encourages openness and within which people feel able to speak-up about their concerns.

**Commissioner requirements**
Whistleblowing is a way for concerns to be raised about possible danger, professional misconduct or financial malpractice that has a public interest to it, usually because it threatens or poses a risk to others, e.g. patients, public, colleagues or the organisation. This applies to all members of staff, volunteers and agency workers.

**Providers will:**
- Have a whistleblowing policy in place, in date and accessible to staff.
- Recognise that an individual does not need to provide firm evidence to raise a concern. However he or she will need to provide as much information as possible about the circumstances that gave rise to that concern.
- Recognise that individuals may prefer to speak to someone in confidence about their concern.
- Ensure that they have mechanisms in place to protect the identity of the whistle blower if consent to disclose is not given, unless required to do so by law.
- Understand there may be circumstances where it is impossible to resolve a concern without revealing an individual’s identity.
- Ensure that no one is discriminated against or suffers any detriment as a result of raising a concern.

**Individuals should:**
- Wherever possible, raise any concerns with your line manager or lead clinician at the first instance, either verbally or in writing; providing as much information as possible.
- Arrange other reporting routes if it is not possible to raise the matter with the line manager or lead clinician.

If staff are still unsure about whistleblowing or would like further confidential advice, then they should contact their union or the whistleblowing helpline. The helpline is a free-phone service for employees, and organisations working within the NHS and social care sector, and is for:

- NHS staff (including trainees and agency staff);
Staff in the social care sector (including trainees and agency staff);
NHS and social care employing organisations;
Contractors for the NHS and social care sector;
Trade unions; and
Professional bodies.

Telephone 0800 072 4725 or email enquiries@wbhelpline.org.uk.

We recognise there may be circumstances when you may need to report to an outside body. Other bodies you can report to include:

Audit Commission
Telephone 0303 444 8346
www.audit-commission.gov.uk/about-us/contact-us/whistleblowing

Care Quality Commission
CQC National Correspondence
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone 0300 061 6161 | Email enquiries@cqc.org.uk

National Patient Safety Agency
4-8 Maple Street
London W1T 5HD

NHS Counter Fraud and Security Management Services
Weston House 246 High Holborn
London WC1V 7EX
Telephone 0207 895 4500

Quality indicators
- Staff know how to raise a concern and are confident that they will not suffer any detriment as a result of this.
19. Medicines management

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<td>Medicines management</td>
<td>Amanda Pell / Kate Hosken</td>
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**Topic overview**

Across all sectors of care it is estimated that at least six per cent of emergency admissions are a direct result of problems with medicines. Data within Cornwall shows that many of our care homes residents take multiple medications and as such are at greater risk of drug interactions and medicine related admissions to acute care.

Regulation 12: Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part three) states that a registered person must ensure “the proper and safe management of medicines” in order to comply with the regulations.

**Commissioner requirements**

The commissioner expects that homes will manage the safe ordering, receipt, storage, administration, and disposal of medication in the home in such a way as to ensure that people get the medicines they need when they need them, managing waste and reducing the risk of medication errors. Ordering of medication must not be delegated to a third party (e.g. supplying pharmacy).

**Providers will:**

- Have a robust medicines policy that covers all aspects of ordering, receipt, storage, administration and disposal of medicines. All staff will need to evidence that they have read and understood this document and the expectations placed upon them and evidence that they abide by it.
- Manage day to day administration of medicines that complies with the medication policy.

Specifically they will ensure:

- That a medication policy is in place which is monitored and reviewed regularly;
- The medication policy should include all aspects of medicines management as covered in the NHS Kernow document ‘medicines management framework for care homes’;
- All staff involved in medicines management have completed an accredited training course and refresher courses. Medication training should include basic information on common types of medicines and their use, the legislative framework for the use of medicines in care homes, how to safely administer, receive, store and dispose of medicines, how to support the resident in taking their medication and promote their rights and how to effectively and safely record and report on the use of medicines;
Orders for medication are placed in a timely manner to reduce the risk of a patient being without medication, for example, not ordering last minute or at weekends. A procedure should be in place for obtaining emergency supplies of medicines for example on bank holidays;

Staff ordering medication have protected time for the task;

At least two members of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff. Stock balances are checked before orders are made and particularly for medicines that are prescribed as “when required” and inhalers;

All medication is stored safely and securely and medication trolleys must be secured to a wall when not in use;

Keys to medication storage areas are always in the possession of a trained senior member of staff;

There should be a clear audit trail for the transfer of keys for the medication storage areas;

The medication policy includes a process for the administration of “when required” or “as needed” (prn) medicines ensuring that residents are monitored to assess the need for “when required” or “as needed” (prn) medication e.g. reviewing the need for analgesia or laxative before administration;

Medication is only administered to the person for whom they have been prescribed, labelled and supplied (including dressings and nutritional supplements, but excluding homely remedies);

There is a policy in place for the ordering, receipt, administration, storage and destruction of Controlled Drugs (CDs) and that this policy includes the reporting of incidents that involve CDs (including reporting to the CD Accountable Officer for NHS England at england.southwestcontrolleddrugs@nhs.net);

All CDs are stored in a metal cupboard which complies with the misuse of Drugs (Safe Custody) Regulations 1973;

CD Registers are kept from two years after the date of the last entry made;

There is a policy in place for warfarin, which includes the requirement for changes in dose to be confirmed in writing;

The medication policy contains a process for the management of patient safety / CAS alerts and ensures that all alerts received by the care home are cascaded to all relevant staff and are revisited to ensure continuing compliance;

A policy exists for those who wish to retain responsibility for the self-management of some or all of their medication and a record are maintained of current medication for these residents; and

A record of medication returned to pharmacy or disposed of via carrier is made.

Quality indicators

**Ordering and receipt of medication:** Residents are not without their medication because there is no stock in the home.

**Medication policy:** Active and in date, covering all aspects of medicines management, regularly reviewed and signed as read by all staff within the last 12 months
Supporting information

- NICE SC1 Managing medicines in Care Homes: https://www.nice.org.uk/guidance/sc1
- NICE CG76. Medicines Adherence – Involving patients in decisions about prescribed medicines and supporting adherence: http://www.nice.org.uk/CG76
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline [NG5] Published date: March 2015: https://www.nice.org.uk/guidance/ng5 (Accessed 26 May 2017)
20. Clinical skills and procedures

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<tr>
<td>Clinical skills and procedures</td>
<td>Marie Prior</td>
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Topic overview
Clinical staff within care homes needs to be both competent and confident in undertaking a range of clinical skills and associated procedures for residents in their care.

Commissioner requirements
It is expected that care home providers will support their clinical staff in attaining, maintaining and evidencing competence in undertaking the skills identified in this operating standard.

Providers will:
Provides will ensure that the clinical management skills listed below are provided and available 24 hours a day as part of registered nursing care delivery.
It should be noted that separate operating standards exist for a number of the clinical management skills listed:

- Anticipatory care planning
- Bowel management
- Continence management
- Dementia management
- Diabetes management
- End of life care
- Falls prevention
- Hydration management
- Management of acute deterioration
- Management of complex wounds
- Management of pressure ulcers
- Management of urinary tract infections
- Medicines management
- Nebuliser and inhaler management
- Non-complex leg ulcer management
- Nursing management of LTC’s
- Nutrition management
- Pain management
- Palliative care planning
- Personalised care planning
- Prevention of pressure ulcers
- Responding to changes in condition
- Symptom management and review
- Tissue viability

Providers will also ensure that staff employed by the home are competent in undertaking the clinical procedures listed below and that these skills are available 24 hours a day as part of registered nursing care delivery:

- Administration of ear drops
- Administration of eye drops
- Blood glucose monitoring
Operating standards for care homes
May 2017

- Blood pressure measurement
- Enteral feeding
- Neurological observations
- Pulse measurement
- Respiratory rate measurement
- Sub cut and IM injections
- Temperature measurement
- Venepuncture

- Catheterisation
- Insulin administration
- Oxygen administration
- Pulse oximetry
- Suction
- Supra pubic re catheterisation
- Urinalysis

- Compression bandaging
- Manual handling
- Peg feeding
- Removal of sutures
- Sub cut fluid therapy
- Syringe driver management
- Vaginal pessaries

- Manual handling
- Neurological observations
- Oxygen administration
- Suction
- Supra pubic re catheterisation
- Urinalysis
- Vaginal pessaries

Quality indicators
- Clinical skills and procedures: Clinical staff are trained and individually they have evidence that are maintaining their competence in undertaking the clinical skills identified in this standard.
21. End of life care

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<td>End of life care</td>
<td>Jo Smith / Gina Starnes</td>
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**Date** | **Review date**
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May 2017 | May 2018

**Topic overview**
This operating standard is written based on the principles of the Gold Standards Framework in Care Homes (GSFCH) training undertaken by nursing homes in Cornwall.

In Cornwall 24.3 per cent of deaths occur in care homes. In 2008 the first national strategy for end of life care in England galvanised the health and social care system with three key insights:

1. That people didn’t die in their place of choice;
2. That we needed to prepare for larger numbers of dying people and
3. That not everybody received high-quality care.

It is important to build on the strategy, but to reframe it in today’s context with its emphasis on local leadership, service delivery and accountability. So, in this standard we use:

- Ambitions for palliative and end of life care;
- Gold Standards Framework in care homes; and
- NICE guidance and quality standards: care of dying adults in the last days of life
- Priorities for care of the dying person

Care home support must be focused around the individual and those important to them, locally led and delivered, and supported across all communities.

**Commissioner requirements**
The commissioner expects that providers will provide end of life care within the Ambitions / GSF framework. By doing so:

- Each person is seen as an individual;
- Each person gets fair access to care;
- Maximising comfort and wellbeing;
- Care is co-ordinated;
- All staff are prepared to care; and
- Each community is prepared to help.

**Providers will:**
Ensure the team has a system in place to identify those residents who are considered to be in the last year of life, best practice suggests utilising the GSF prognostic indicator guidance tool, incorporating GSF needs based coding system.
Ensure residents clinical needs are assessed, in a holistic and dignified manner, demonstrating the use of appropriate assessment tools. Residents receive appropriate symptom and pain relief when required and without delay.

Offer advance care plan discussions to all residents, determining resident’s preferences and wishes and aligning care accordingly. Where the resident lacks capacity, facilitate best interest meetings, ensuring care is delivered in line with Mental Capacity Act (2005).

Engage in effective cross boundary communication to the wider healthcare team, ensuring information about individuals who are approaching the end of life is available, in the right format, at the right time, to the right people.

Ensure individual end of life care plans are implemented when residents’ enter the last days of life, aligning the care given with the five priorities for care of the dying person.

Ensure there is good care and support for the bereaved and staff, including staff supervision and written information and signposting for bereavement care.

Incorporate reflection as standard practice, ensuring team reflection occurs following the death of a resident and following any acute hospital admissions. Discussion as a team to reflect on the care given, highlighting any key areas for improvement.

Ensure staff educational needs are being met. All staff are skilled in needs assessment, care planning and advance care planning, ensuring staff are confident to facilitate effective conversations regarding end of life care.

**Quality indicators**

**Clients approach death / die in a supported, well managed way:** Residents achieve their preferred place of care / death. They are cared for by staff who are confident and competent in end of life care.

**Quality assurance:** Staff have mechanisms to evaluate complaints and compliments relating to end of life care. After death analysis / reflective practice and education opportunities in place for staff.

**Supporting information**

**Local**

- Cornwall guidance for Anticipatory Prescribing / Symptom Control and 24 hr specialist palliative advice line number: [http://rms.kernowccg.nhs.uk/content/PRESCRIBING%20PALLIATIVE.pdf](http://rms.kernowccg.nhs.uk/content/PRESCRIBING%20PALLIATIVE.pdf)
National

- End of Life Care for All (e-ELCA) free access to over 150 interactive sessions, including advance care planning, assessment, communication skills, symptom management, comfort and well-being, social care, bereavement and spirituality: http://www.endoflifecareforall.com/
 Operating standards for care homes  
May 2017  

22. Diabetes  

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<td>Diabetes</td>
<td>Jill Churchill</td>
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**Date**  
May 2017  
**Review date**  
May 2018  

**Topic overview**  
Diabetes is a chronic disease that occurs when the body does not produce enough insulin and/or the body cannot effectively use insulin which leads to the person having high blood sugars (Hyperglycaemia) and this in turn can cause multiple vascular risk factors. The necessary lifestyle changes and complexities of management often make diabetic care complex and time consuming, therefore patient education and self-monitoring are a vital part of optimum care.

Good communication is essential between healthcare professionals and patients, and this should be supported by evidence-based written information (The Yellow Diabetic Book - Understanding Diabetes’ produced by the Cornwall Diabetic and Endocrine Centre at RCHT) which can be tailored to individual needs. A structured education programme is recommended to all patients at the time of initial diagnosis and then as required following regular assessment of need, (See NICE NG17 Diabetes Patient Education Models).

It is important that patients have the opportunity to make informed choices about their care and treatment. Dose Adjustment for Normal Eating (DAFNE) is recommended for patients with Type 1 diabetes, which can be accessed via the diabetic specialist nurses or hospital consultants.

- **Type 1 diabetes:** In Type 1 diabetes, there is severe lack of the hormone insulin, which is made in the pancreas. Insulin is needed to help glucose to move from the bloodstream into the cells of the body, where it is used as energy. Type 1 diabetes usually arises in childhood or early adulthood and people who develop it will need insulin straight away.

- **Type 2 diabetes:** Type 2 diabetes is much more common than Type 1 and usually arises after age 40 years. The body can still make some insulin, but there may not be enough, or it may not work effectively. Type 2 diabetes can sometimes be managed with a sensible eating plan, but many people will also require tablets to lower the blood glucose. Type 2 diabetes is a progressive disease and some people with Type 2 diabetes eventually require insulin, however, they do not then become a Type 1 diabetic, they are still a Type 2 diabetic who requires insulin.

**Commissioner requirements**  
The commissioner expects that all providers will ensure that they deliver high quality diabetic care to all patients/residents, to meet individual needs in accordance with national standards; delivering best practice at all times.
Providers will:
Ensure that:
- All staff have a working knowledge of diabetes, diabetic medications and treatment of hypoglycaemia;
- A diabetic diet is provided for all diabetic patients/residents;
- Have a capillary blood testing monitor available with single use lancets;
- Have a sharps bin available for the disposal of all sharps; and
- Complete relevant diabetic checks.

Annual health checks to include:
- Blood tests;
- Foot check including pulses, sensation and foot risk classification. Referral to Podiatry should be made for an initial assessment at diagnosis and for any identified problems or care need. For any urgent issues refer via the emergency Podiatry line - 01579 373550;
- BP and pulse (BP target 140/80);
- Assessment for presentation of any symptoms;
- Lifestyle advice including dietary assessment and advice, with referral to specialist dietician/health promotion service/exercise on referral programme as needed;
- Full urinalysis (dip test) and urine for Albumin/Creatinine ratio (UACR);
- Smoking status and cessation advice if required; and
- Review of any medication, including side effects.

For patients on insulin also include:
- Review of self-monitoring capillary blood glucose records to assist with optimising control;
- Examination of injection sites for signs of lipohypertrophy formation which may affect absorption of insulin. Lipohypertrophy is when fatty lumps appear on the surface of the skin and is a fairly common side effect of insulin injections;
- Check the patient has an insulin passport and encourage to keep information contained within it up to date to minimise the possibility of errors in the provision of the medication or administration if reliant on others to provide care for any reason e.g. hospital admission;
- Check the patient is competent and confident to self-administer insulin and that any equipment provided is suitable e.g. pen devices, blood testing; and

Interim check (three to six monthly depending on control)
- Blood test;
- Discussion of result;
- Blood pressure;
- Full urinalysis;
- Lifestyle advice; and
Follow up on any problems identified. Assess understanding of medication and ability to self-care as part of on-going support.

Quality indicators
- The home provides high quality person centred diabetic care that reflects the changing needs of the individual.
- The home has relevant tools to support them in their work.
- Staff have relevant training and updates in diabetes.

Supporting Information
- Diabetes UK: https://www.diabetes.org.uk/?gclid=CItbPmlSxkMgCFeESwwodlXcMMw
- National Institute for Health and Care Excellence: https://www.nice.org.uk/guidance
- NHS Diabetes: insulin, use it safely (2011) - Refer to NICE guidance regarding drug management.
  o NG28. Type 2 Diabetes in Adults. December 2015 (Updated May 2017).
  o NG17 - Type 1 Diabetes in Adults: diagnosis and management. August 2015 (Updated July 2016)
  o NG18 – Diabetes (Type 1 and Type 2) in children and young people; diagnosis and management. August 2015 (Updated November 2016)
  o NG19 – Diabetic Foot Problems: Prevention and Management. August 2015 (Updated January 2016)
23. Risk of VTE in care homes

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<td>Risk of VTE in care homes</td>
<td>Andrew McSorley - RCHT</td>
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<td>Jan Varney - NHS Kernow</td>
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**Date**  
Review date: May 2018

**Topic overview**
Around 60,000 deaths a year in the UK are due to venous thromboembolism (VTE) with around 50 per cent of these associated with hospital admission. Care home residents have a similar risk profile for hospital associated thrombosis however the epidemiology of VTE in care homes remains unclear and the VTE risk profile of UK care home residents has not been investigated. The findings report from the Dublin conference 2016 (Author institutions: University of Birmingham, University of Oxford) suggest care homes residents are at high risk of VTE yet there is very limited use of VTE prophylaxis. While there are clear guidelines and recommendations in place to reduce the risk of VTE in hospital in-patients there are no such measures in place for care home residents.

**Clinical bottom line**
Venous thromboembolism may present as deep vein thrombosis (DVT) or pulmonary embolism (PE) and is a challenging problem in older adults in care homes.

Deep vein thrombosis (DVT) is a clot which forms inside a vein commonly in the lower limb and may be asymptomatic or symptomatic (with leg pain or swelling). If DVTs are not treated promptly, a long term condition complication post thrombotic syndrome (PTS) can occur leading to increased risk for later VTE development and increased treatment costs and mortality rates. In pulmonary embolism (PE), the clot embolises to the pulmonary arteries, causing shortness of breath, chest pain, haemoptysis, heart failure and even death. The symptoms of PE can be hard to detect and may be masked by the symptoms of other underlying cardiopulmonary conditions. The pathogenic factors believed to be responsible for VTE are generally considered to involve vascular wall injury, hypercoagulable state and impaired circulation, collectively known as Virchow’s triad, although the absence of one or more of these does not preclude the occurrence of VTE. Many individual risk factors can contribute to an overall increased risk of VTE. The symptoms of VTE are often subtle in older residents and since elderly residents have a relatively high tolerance for reporting pain these symptoms often go unreported. It is possible for patients to have no symptoms at all; this is known as a “clinically silent” event. Efficient prevention of VTE is a challenging task for residents in care homes as so many are immobile and wheelchair dependant and prevention of VTE may be a clinical concern for staff working in these long term facilities.

**Commissioner requirements**
The commissioners expects that all providers will deliver high quality care for all patients whilst monitoring their risk factors for the potential of VTE, initiating
preventative/proactive measures to prevent this occurring. In the absence of national guidance or specific assessment tools regarding VTE prevention in non-acute settings, providers are expected to monitor patients for any signs and symptoms of VTE at an early stage and get medical help as a matter of urgency.

Providers will:
Monitor known risk factors for VTE:
- Immobility: Bed bound, wheelchair bound. Leg exercises can reduce venous stasis and should be encouraged. Even patients who are bed-bound can usually still do regular, gentle exercises such as ankle circling or toe stretching. Elevate the foot of their bed or prop up their feet with a pillow to prevent their circulation from pooling. If the patient is confined to a chair, encourage them to exercise their lower legs by raising their heels, keeping their toes on the floor, and then lowering their heels again, ten times. Then raise and lower their toes ten times, keeping their heels on the floor. They need to do these exercises on a regular basis;
- Previous DVT or PE;
- Stroke;
- Dehydration: ensure adequate hydration see operation standard 1. (Oral hydration);
- Recent surgery: Orthopaedic hip/knee, abdominal surgery in cancer. These residents may be on extended prophylaxis treatment from discharge from hospital; and
- Significant co-morbidities: cancer, heart disease, inflammatory conditions.

Signs and symptoms:
- **DVT**: Usually develops in the calf but may also form in the thigh or other deep veins with unexplained unilateral swelling, tenderness or pain. Sometimes despite these symptoms, no obvious DVT is found.
- **PE**: Breathlessness, either suddenly or becoming gradually worse, chest pain which can be worse on breathing in. Slight fever, rapid heartbeat, cough with or without blood stained sputum and sudden collapse.

Quality indicators
There are no national assessment tools or guidance for the prevention/reduction of venous thromboembolism in care homes at the present time; hence emphasis for this particular operating standard is on awareness regarding VTE.

Supporting Information
- Risk of Venous Thromboembolism in care home residents - Conference Dublin 2016 - Author Institutions: University of Birmingham, University of Oxford.
- NICE clinical guidance 92 London: Reducing the risk of venous thromboembolism- (Deep vein thrombosis and pulmonary embolism) in patients admitted to hospital - National Institute for Health and Clinical Excellence
24. One to one in the care home setting

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<td>One to one in the care home setting</td>
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**Topic overview**

NHS Kernow is responsible for commissioning consistent care across the county within all care settings. Within this there is a need for all requests for additional one to one care to be presented to NHS Kernow with clinical evidence at the time of request.

NHS Kernow needs to ensure that the least restrictive practice is always the outmost consideration for all clients, whilst meeting their individual needs and that the one to one support is reviewed in a timely manner.

**Commissioner requirements**

The commissioner expects that:

- The care setting will ensure that plans of care, treatment and support are implemented, flexible, regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service - please see further information in quality Indicators.

The provider must demonstrate:

- That requested commissioned additional care needs (one to one) are above and beyond the expectation (or requirement) of the registration of the care setting;
- The care setting registration is appropriate to the level of need of the client;
- The identified additional needs can be met by input from Cornwall Partnership NHS Foundation Trust (CFT);
- Behaviours exhibited will cause undue harm to self or others; and
- Additional staff for one to one will not be used to meet the staffing level within the care setting.

Exclusions:

- NHS Kernow is unable to commission additional one to one care for symptoms typical of the diagnosis of dementia;
- NHS Kernow is unable to commission one to one care for falls prevention; and
- NHS Kernow are unable to provide a transfer of one to one from acute/community hospital or other residential setting.

**Providers will:**

- Contact CFT case co-ordinator in the first instance to enable a full assessment of need to be completed;
- Use NHS Kernow’s buyers team to procure one to one if agency staff required;
- Ensure that timely reviews are completed with CFT care co-ordinator;
• Provide robust care plans and clinical evidence for any additional care needs commissioned;
• Inform CFT staff of any changes in presentation which may allow a reduction in one to one care and to be least restrictive; and
• Be aware that all additional need (one to one) is a temporary measure. The expectation is that the care setting will be able to formulate a care plan to prevent or limit any harm possible.

Quality indicators
A care plan will be required for each application.

The care plan needs to demonstrate individual and specific care needs related to the additional care need request:

• **Identified need:** How this is need is presenting, behaviour, emotional requirements, description of relevant incidents.
• **Risk assessment:** What are the risks to self, others, environment etc? How do you make the care as safe as possible?
• **Goal setting:** what do you want to achieve for the client.
• **Intervention:** purpose of the additional staff, how are they going to meet the client’s needs, what interaction they are required to perform? How is this information going to be recorded? Who is going to be contacted if there are further concerns?
• **Outcome:** Date of next review.
• What interventions worked well, what was less effective. Identified triggers. Clients’ likes and dislikes.
• How the needs are going to be met in the future.